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Editor - Captain L. B. Marshall, MC, USN

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TABLE OF CONTENTS

Circular Letters:

Nerve Gases: The "nerve gases" are potential chemical warfare agents which might be used. They are a group of highly toxic chemical agents having a physiological action similar to, but much more prolonged than, physostigmine. They are readily absorbed through any body surface, including the respiratory tract, the eyes, the gastrointestinal tract and even the intact skin. Symptoms induced by incapacitating or lethal doses begin almost immediately and progress at a rapid rate. The rescue and treatment of nerve gas poisoning cases, therefore, present very difficult problems for the medical services.

In this article the symptoms and treatment of nerve gas poisoning are described. This information will be enlarged upon in a manual on chemical warfare which is soon to be published for medical officers.

The nerve gases inhibit the formation of cholinesterase, thereby liberating acetylcholine. The acetylcholine congregates at the following neuromuscular mechanisms:

(1) Synapse central nervous system, causing irritability, central defect in respiration, confusion and convulsions.
(2) Synapse of parasympathetic and sympathetic ganglia, producing stimulating action (nicotinic effect), tachycardia, increase in blood pressure and blood sugar.
(3) Synapse parasympathetic effector junction, producing stimulating action (muscarine effect) and causing miosis (which appears early from vapors), retrobulbar pain, increased nasal, salivary and bronchial secretions, bronchospasm, slowing heart rate, and increased motility of the gastrointestinal tract, resulting in nausea, vomiting, diarrhea and cramps.
(4) Myoneural junction (between skeletal muscle and nerve), causing (in moderate concentration) muscular fasciculation and (in larger concentration) flaccid paralysis.

The type of exposure to which the individual is subjected determines the nature of the response. Vapor affects first the lungs and eyes, and is later absorbed in the blood stream. Liquid affects first the skin, second the muscles (producing fasciculation), and then is absorbed into the blood stream. Ingestion affects the gastrointestinal tract, producing increased motility and, when the nerve gas is absorbed into the blood stream, will produce the generalized symptoms described above. In general, when nerve gases enter the circulatory system, the victim will develop all the symptoms and signs described, depending upon the C. T. factor (concentration x time in minutes).

Treatment must be prompt, expeditiously and concisely given, when liquid or vapor gases are being used. It may be very difficult to determine the concentration or the time element, but one should avail oneself of all the necessary precautions. The psychogenic manifestations that may occur as a result of a suspected attack will result in bizarre symptoms and, to those familiar with the symptomatology caused by nerve gases, will simulate the signs and symptoms produced by

nerve gases. Protective clothing and gas masking, while possibly inadequate, will at least afford some protection in decreasing the effect of concentration and time interval, and thus enable faster recovery than might otherwise be possible. Every attempt should be made to prevent further absorption.

The prime first-aid measures are:

(1) If vapor, mask and remove from area.
(2) If liquid, mask, remove from area, decontaminate skin with a buffer solution. Cut clothes, blot, don't rub, wash with 5 percent sodium bicarbonate or water. Don't rub; gently wash.

The treatment of anoxia, whether it be from bronchial constriction or from central nervous system depression of the respiratory system, consists of artificial respiration, Emerson-Schaefer-Ivy method (manually lifting and rolling hips, hyperextending back, and pressure applied to thorax), and administration of high concentration oxygen or use of a resuscitator (mechanical if available). (See Medical News Letter, Vol. 16, No. 9, page 5.) Do not use atropine or like substances at this time, because it will produce ventricular fibrillation and then death.

When anoxia is not present, the treatment consists of atropine, homatropine for the eyes, and tridione for convulsions. Atropine blocks the acetylcholine at the effector junction and at the synapse of the central nervous system but does not block at the myoneural junction of the skeletal muscles. The indications for administering atropine are:

(1) For severe symptoms, if persistent or progressive, 2 mg. every 15 minutes until the cardiorespiratory symptoms are relieved and some dryness of the mouth appears.
(2) As a prophylaxis (skin with fasciculation), 2 mg. from every 1/2 to 1 or 2 hour interval.
(3) To relieve miosis and retrobulbar pain, administer homatropine drops to eyes as local prescription.

Tridione, 1 Gm. intramuscularly or intravenously is administered for convulsions until 3 to 4 Gm. are given. The 1 Gm. dose may be given as often as discretion would allow, usually at 1/2 to 2 hour intervals until required results are attained. If convulsions persist, barbiturates can be used.

The time interval before treatment with atropine is begun is very important. Atropine injected before respiratory paralysis results in good prognosis. Atropine injected after respiratory paralysis has set in results in ventricular fibrillation and then death. When it is justifiable to apply artificial respiration to prevent respiratory paralysis and atropine is injected, the prognosis is considered good. (Captain M. J. Hantover, MC, USN) (See Medical News Letter, Vol. 17, No. 9, page 2)

ACTH and Cortisone--Miracle Therapy or Medical Tool?

Uses of ACTH and Cortisone

ACTH and Cortisone have been tried in the following diseases and it has been found that they–

ARE OF SOME VALUE IN–

Agranulocytosis
Alcoholism (?)
Allergies, various (in addition to those specifically mentioned here)
Allergic rhinitis
Asthma
Atopic dermatitis
Blepharitis
Choroideremia
Choroiditis
Conjunctivitis vernalis
Dermatomyositis
Drug sensitization
Eczema
Exfoliative dermatitis
Erythema multiforme
Fevers (apparently irrespective of etiology, though probably normalization of the temperature is not always an advantage)
Gouty arthritis
Hay fever
Hemolytic anemias of various kinds
Herpes zoster
Hodgkin's disease
Idiopathic hypoglycemia
Iritis
Iridocyclitis
Keratitis
Leukemias (various)
Loeffler's syndrome
Lupus erythematosus disseminatus
Lymphosarcoma
Nasal polyps
Nephrosis
Neurodermatitis
Ophthalmologic conditions (especially those characterized by allergic and inflammatory manifestations)
Periarteritis nodosa
Pneumonia (pneumococcus, "primary atypical")
Psoriasis
Retinitis (centralis, pigmentosa)
Retrobulbar neuritis
Rheumatic fever
Rheumatoid arthritis and spondylitis
Serum sickness
Tuberculosis of the larynx
Ulcerative colitis
Urticarias (various)
Uveitis
Vasomotor rhinitis

MAY BE VALUABLE IN–

Boeck's sarcoid
Glaucoma
Hepatitis
Hypertension
Hyperthyroidism (especially in normalizing the BMR and reducing the exophthalmos)
Keloids
Liver cirrhosis
Myasthenia gravis
Nephritis (especially if due to allergy)
Pemphigus
Scleroderma
Thromboangiitis obliterans (Buerger)

ARE OF NO VALUE IN–

Amyotrophic lateral sclerosis
Carcinomas of most types
Congestive heart failure
Diabetes mellitus
Multiple myeloma
Poliomyelitis

MAY PRODUCE HARMFUL EFFECTS IN–

Acne vulgaris
Congestive heart failure
Cushing's syndrome
Diabetes mellitus
Hypertensive disease of certain types
Nephritis of certain types
Osteoporosis
Peritonitis
Septicemia
Wound healing

UNDER CERTAIN CONDITIONS MAY ACTUALLY PRODUCE–

Acute pulmonary edema
Ascites
Marked decrease in resistance to infections
Obscuring of the criteria of disease (e.g., fever and abdominal rigidity in peritonitis, the hematologic manifestations of systemic diseases, the acceleration of the pulse in acute infections, etc.)

(GP, February '51, J. D. Fox)

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The Oral Use of Cortisone Suspension in Syrup: A suspension of cortisone was administered by mouth in order to evaluate the efficacy of the oral route of administration. This preliminary report is based on experience with 29 patients selected from the medical wards of the Veterans Administration Hospital, San Francisco, and from private practice. Each patient had a disease known to respond favorably to cortisone and severe enough to warrant the use of the hormone.

The injectable suspension of cortisone has a highly disagreeable taste, which can be adequately disguised with one of the standard vehicles, such as syrup of

cherry or orange. The desired quantity of cortisone suspension is added to a measured volume of vehicle, the proportions so adjusted that each cubic centimeter of the mixture contains 1 or 2 mg. of cortisone. The authors have been able to dispense a week's supply of the drug without noting any variation in potency from one dose to the next. The uniformity of clinical response further indicates that the cortisone suspension in syrup retains its effectiveness for at least a week. However, since cortisone has a tendency to settle out of suspension, it is necessary to shake the bottle vigorously before each use.

Twelve patients with chronic disease were first treated with intramuscular injections of cortisone and then with cortisone suspension taken orally, to permit comparison of the 2 methods of administration. In this group were included 8 patients with rheumatoid arthritis and 1 each with chronic gouty arthritis, chronic urticaria, psoriasis and uveitis due to Boeck's sarcoid.

The oral maintenance dose of cortisone could not be determined until 10 to 14 days had elapsed since the last intramuscular dose, because that much time was required for complete absorption of cortisone from intramuscular depots.

For 4 patients with rheumatoid arthritis the minimal dose required to produce complete relief of symptoms was determined for both the intramuscular and the oral route of administration. Corresponding weekly doses were found to be nearly identical for 2 patients, while the minimal effective oral dose was 20 percent and 30 percent greater than the intramuscular dose for the other 2. Even when minimal effective doses were not determined, the oral doses were similar to those generally given parenterally.

Nine patients with chronic disease and 8 with acute disease were treated only with cortisone administered orally. The first of these groups included 6 patients with rheumatoid arthritis and 1 each with rheumatoid arthritis and psoriasis, chronic bronchial asthma and Addison's disease. The group with acute diseases consisted of 4 patients with acute gouty arthritis, 2 with status asthmaticus, 1 with dermatitis venenata and 1 with rheumatic fever. In 3 of these patients the initial oral dose of cortisone was not large enough to produce a therapeutic effect. Ten of the remaining 14 patients showed symptomatic and objective improvement within 4 to 12 hours after therapy was begun. Only 1 of the 14 patients failed to respond within 36 hours. The prompt therapeutic effect of cortisone administered orally indicates that this hormone is absorbed more rapidly from the gastrointestinal tract than from intramuscular depots. When oral cortisone therapy was stopped or the dose was reduced to suboptimal levels, relapse usually occurred within 24 hours, demonstrating the brief duration of action of an oral dose of cortisone.

Experience with cortisone suspension in syrup, as well as with cortisone tablets, leads to the establishment of a few simple rules for the oral administration of cortisone:

1. Because an oral dose of cortisone in syrup is rapidly absorbed, it is usually unnecessary to use large "priming" doses when therapy is initiated.

2. Because the effect of an oral dose of cortisone is dissipated more rapidly than that of an equivalent intramuscular dose, cortisone must be taken orally 3 or 4 times during the waking hours. It has not been found necessary for the patient to take a dose during the night.

3. The minimal effective dose varies widely for different patients and must be determined by trial. The majority of the authors' patients have been adequately maintained on 75 to 100 mg. of cortisone daily, but some have required as much as 200 mg. a day.

4. When the administration of cortisone is changed from the intramuscular to the oral route, it should be kept in mind that some cortisone will continue to be absorbed from sites of injection, the duration of absorption depending partly on the size of the previous intramuscular dose.

5. When administration of cortisone is changed from the oral to the parenteral route, oral administration should be continued, whenever possible, for 2 to 4 days after the first intramuscular dose. This will prevent a relapse during the period of transition.

In the preliminary trial the oral administration of injectable cortisone has proved so satisfactory that it has almost completely supplanted the intramuscular route in the authors' practice. The minimal effective oral dose of cortisone may be slightly larger than the intramuscular dose, but the disadvantages of a larger maintenance dose may be offset by the significant advantages of oral administration.

It has been shown that the effect of cortisone when taken orally is prompt and of short duration, whereas the action of a dose given intramuscularly is slower to appear and may last for a number of days. The fact that oral administration of cortisone usually produces a therapeutic effect within a few hours is of obvious advantage in the treatment of acute disease. The brief action of an oral dose permits prompt termination of the effect of cortisone should dangerous reactions occur.

There is no reason to believe that the hazards of cortisone therapy are reduced by use of the oral route of administration. Although so far hypertension and Cushing's facies have been the only untoward effects encountered by the authors in the oral use of cortisone, salt and water retention, pulmonary edema, hypertension, hyperglycemia and hypokaliemia were looked for at regular intervals. The authors' experience with cortisone tablets indicates that there is no difference in therapeutic effect between these and cortisone in syrup.

The oral route is the method of choice for therapy with cortisone, unless contraindications to oral medication exist. (J.A.M.A., 10 February '51, E. P. Engleman et al.)

The Use of Anticoagulants in Military Medicine: An Army is subject to all of the illnesses and accidents of civilian life; for these the indications for anticoagulant therapy are the same. In addition, military life is associated with hazards which result in an increased incidence of certain types of injuries, the modern repair and treatment of which requires the use of anticoagulant drugs. The loss of manpower and permanent disability resulting from thromboembolic disease in World War II has not been exactly calculated, but the author believes that it might well have equalled several divisions.

The first condition for which anticoagulants were intensively used was thrombophlebitis, with or without embolization. The incidence of this condition is markedly increased by trauma, therefore assuming a grave importance in physical training programs preparatory to combat, in actual combat, and in reparative procedures in military hospitals.

In brief, the effects of anticoagulants can be measured by the figures compiled from many series of cases. Without anticoagulant therapy a soldier with thrombophlebitis in the veins of the legs has a 30-50 percent chance of suffering a pulmonary embolus. After one embolus he has a 20 percent chance of having a fatal embolus. With correct anticoagulant therapy the risk of the first pulmonary embolus is reduced to 5 percent and the risk of death to 0.5 percent. While ligation will prevent a pulmonary embolus from the specific vein ligated, it is now recognized that ligation does not (a) produce an effect on the local thrombosing process or (b) prevent emboli, sometimes fatal, from arising from other veins or, indeed, from the portion of the vein proximal to the ligation. It is, therefore, no longer the treatment of choice. It has been clearly demonstrated that the use of anticoagulants postoperatively as a preventive measure will reduce the incidence of thrombophlebitis. This is advisable in major abdominal and pelvic surgery, but may not as yet be feasible for all surgery.

Men in the military services are also liable to heart disease. Thousands developed rheumatic heart disease during World War II. Many of these have or will develop auricular fibrillation and some will suffer from embolization. The use of anticoagulants, notably long term dicumarol therapy, will prevent in the majority of cases of fibrillation the formation of clots within the heart and their release as emboli. It is the only form of therapy which will attack this problem with any significant degree of success. As proof of its feasibility, the author has treated a series of more than 100 patients from 1 to 5 years with ambulatory dicumarol therapy--a total of over 400 patient years with notable success and without a single death from hemorrhage. However, this type of therapy can only be carried out when it is carefully controlled.

Soldiers also develop coronary thrombosis with myocardial infarction. More than 800 soldiers under 40 died of this condition during World War II. The total of all ages who developed this syndrome would run into many thousands. The study of the Committee on Anticoagulants of the American Heart Association,

carried out on 1031 patients, approximately one-half of whom received anticoagulants, has demonstrated that (1) the death rate from coronary thrombosis with myocardial infarction can be reduced one-third with the use of anticoagulants, and (2) the number of thromboembolic complications can be reduced by three-quarters by the same measures. The indications are clear for the use of these drugs in every case of coronary occlusion unless some definite contraindication exists.

Vascular surgery is now relatively commonplace, although it still demands high technical skill and the sound use of anticoagulants. To achieve the best possible results, heparin should be used freely but wisely during the actual procedure and immediately thereafter and this should be followed by the use of dicumarol or Tromexan for 3 to 4 weeks thereafter. The greatest cause of failure of vascular surgery has been the formation of clots at the site of the surgery and in many instances this has frankly been due to hesitation on the part of the surgeon to use anticoagulants with serious interest and understanding.

Among the most common surgical procedures necessitated by war is the repair of arterio-venous anastomoses produced by penetrating wounds. Their variety is infinite as to structure and location, often taxing the ingenuity of the most skillful of surgeons. To obtain the best results a team from either the surgical or medical services trained in anticoagulant therapy should follow the patient through his operation and thereafter. It should not be left to the busy surgeon to handle this aspect of the case unless he has special interest and knowledge in the field.

It appears from the work of Lange and others that following frostbite the administration of heparin promptly will reduce the loss of tissue. This is an interesting though as yet not conclusive observation which might be even more important if an anticoagulant should be developed which taken by mouth would produce an anticoagulant effect within an hour of ingestion. Such a development is not at all unlikely in the light of recent developments. Pending such an anticoagulant this approach to frostbite must be largely confined to patients admitted promptly to hospitals capable of administering heparin. Too frequently the position of the soldier who is subjected to frostbite is such that many hours or even days may pass before he can get such treatment. It does, however, open vistas for contemplation. The first anticoagulants, heparin and dicumarol, were far from completely satisfactory, but their use was a great advance in therapy. Now better anticoagulants are being sought and some promising ones are appearing. Tromexan, also a coumarin derivative, acts more quickly than dicumarol, and its action ceases more rapidly when administration is discontinued. It appears to produce fewer hemorrhagic complications and does represent, at least in some ways, an improvement but is probably not the ultimate anticoagulant. BL-5, another coumarin, is under study at present. Phenylindanedione is also being tested. These all affect the prothrombin activity of the blood to a greater degree than the clotting time.

Paritol, a synthetic polysulfuric ester of polyanhydromannuronic acid, acts on the clotting time as does heparin. It is much less expensive than heparin but there have been a few shock-like reactions so that the past lots cannot be recommended for general use without reservations. This is, however, the first significant step in the direction of a substitute for heparin and it is hoped that subsequent lots may be free from the component responsible for the reactions. (Mil. Surgeon, February '51, I. S. Wright)

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Radioactive Iodine in the Treatment of Hyperthyroidism: The results of radioactive iodine therapy reported in the literature have dealt almost entirely with the treatment of toxic diffuse goiter (Graves's disease). The effectiveness of I^{131} treatment for this type of hyperthyroidism has been well established, and the problem of the most judicious selection of cases for treatment becomes increasingly clearer.

The hyperthyroidism of nodular goiter has been treated with I^{131} far less frequently than that of toxic diffuse goiter. There is no common agreement on the acceptability of I^{131} for the treatment of this type of hyperthyroidism. It seems to be the present consensus that surgical treatment is the preferred method, provided the operation can be performed safely; since pre-treatment with thiouracils can eliminate the hyperthyroidism, surgical intervention is in most instances a safe procedure.

In cases in which a discrete adenoma exists or in which risk of carcinoma is, for other reasons, suspected, the surgical method is generally conceded to be the preferable form of treatment, since it is the only mode of therapy in which the nodule can be removed. This argument is considered by the authors to be more appropriate in cases in which a single true adenoma is present than in cases of multinodular goiter, in which some nodules are likely to remain after subtotal thyroidectomy.

Crile, McCullagh, and Glasser have suggested that toxic nodular goiter may respond to I^{131} differently from toxic diffuse goiter, in that larger doses and more treatment are required in controlling nodular goiter. Gordon's results, however, show no real difference between the dosage requirements.

In the series here reported, the authors' doses in toxic diffuse goiter have been generally as follows: For a gland judged to be near normal size, i.e., about 30 Gm., 4 millicuries is given, with 1 additional millicurie for each additional 10 Gm. of gland. Thus, if a gland is twice normal size, 7 millicuries is given, and a gland estimated to be 90 Gm. in volume receives 10 millicuries. In a few instances in which glands were unusually large or hyperthyroidism extremely severe, additions have been made so that one patient was given an initial dose of 14 and one of 17 millicuries.

Treatment with I^{131} was usually selected because of old age, poor cardiac status, failure to maintain a remission after propyl or methyl thiouracil therapy or aversion to surgical intervention. In the past this treatment has been reserved generally for persons over 40 years of age because of the remote possibility of carcinoma appearing in the thyroid many years following radiation therapy. The present trend is toward leniency in adhering to this age limit, especially when other indications exist. The age range in recent series was from 7 to 74 years. In all young patients the parents of the patients are asked to share the theoretical risk of late complications. In the authors' series, all patients but one were over 40 years of age.

I^{131} treatment was given 203 patients having diffuse goiters and hyperthyroidism and to 78 patients having nodular goiters and hyperthyroidism. Of the 203 patients with toxic diffuse goiter (Graves's disease), 16 were not in remission when last seen, and, of these 16, two had been followed only 2 months. Only 4 of the remaining 14 are known to have continuing hyperthyroidism 6 months or more after their initial treatment. The recurrence rate has been about 3 percent.

In toxic diffuse goiter there is some relationship between the height of the metabolic rate and the dose of I^{131} required for remission. Those patients with high basal metabolic rates required a dose approximately 15 percent higher than those with low rates. The relationship between the size of the gland and the dose requirement is much closer. Control of the hyperthyroidism in patients with large glands may require 75 percent more than in patients with small glands. There is, however, a great variation in dose which cannot be accurately predicted.

In the group of 78 patients with nodular goiter and hyperthyroidism, 18 remained hyperthyroid. Severity of hyperthyroidism appeared to bear little relationship to the size of the total dose needed for remission. Size of gland and size of total remission dosage were somewhat more closely related, but less definitely than in toxic diffuse goiter. In order to achieve remission in toxic nodular goiter much larger doses and a longer time were required than for cases of toxic diffuse goiter.

Hypothyroidism, the only complication recognized in this series, was present in approximately 10 percent of the patients with toxic diffuse goiter. No case of hypothyroidism in a patient having toxic adenoma treated with radioactive iodine has yet been observed.

It is concluded that I^{131} is acceptable treatment in certain selected cases of nodular goiter, provided the shortcomings of the method are accepted. (Arch. Int. Med., January '51, E. P. McCullagh and C. E. Richards)

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Hysterical Amblyopia in Children and Young Adults: Ocular hysteria, while rare, is not so unusual as to be regarded as a medical curiosity and should be seriously considered in cases of amblyopia of unknown cause.

The author presents a study of 19 cases of ocular hysteria, all with amblyopia, seen in a 4 year period. All patients were examined either in the office or in the ophthalmologic clinics of the Worcester City Hospital and the Boston City Hospital.

The condition was seen mainly in children and young adults. The youngest patient was 9 years of age, the oldest was 50, all but 4 were under 30 and over 40 percent were children under 13. The series consisted of 13 females and 6 males. The males were equally divided into adults and children. The 13 females were also roughly divided into 2 equal groups, 6 adults and 7 children.

The ocular hysteria was usually manifested by amblyopia, considered chronic and gradual in onset, although acute episodes were reported. The chief complaint of all the patients was poor vision in one or both eyes; all but 4 patients had bilateral involvement. Considerable variation in the severity of the visual impairment was noted. Three patients had so little vision that they were either unable to perceive light or had difficulty with light projection. The vision of the majority was between 20/70 and 20/200. In all cases the vision was unimproved by the initial refraction and it was only after further investigation, with careful field studies, that the diagnosis of hysterical amblyopia could be established and that the admission of visual improvement could be elicited.

In this series of cases the disease was more frequent in young females. The few adult males observed were either injured ex-servicemen or workmen. Unexplained amaurosis, especially in a female, between the ages of 9 and 35 years warrants the most careful investigation for hysteria. The peripheral field findings are the most important in establishing a diagnosis. There is variation in the size of the field but practically no difference in its characteristics. Once a small circular field has been determined and it is then found that the identical field is present with the patient placed at a considerably greater distance from the screen, the diagnosis of hysteria can be made. No other functional condition simulates this finding of a tubular field.

The phenomenon of hysterical amblyopia is fascinating when it is realized that the patient has subconsciously refused to see and has relegated his visual sensations to the subconscious. The development of hysteria is the response of the patient to a seemingly impossible situation. He refuses to see and hides behind a protective covering of blindness, which excuses him from continuing in the competition of life. Fortunately, true vision continues to exist in the subconscious; it does not deteriorate permanently and, with proper psychiatric care and guidance, a liberation of vision can be brought about. (A.M.A. Arch. Ophth., January '51, E. R. Yasuna)

Arteriectomy for Arterial Obstruction in the Extremities: Occlusive arterial disease of the extremities is a relatively common affection observed in middle and old age. The pathologic process is a progressive one from the onset of atherosclerosis to complete obliteration of segments of the vascular tree. The objective sequelae of such disturbances are trophic changes in the involved extremities. Subjectively, intermittent claudication with functional incapacity is noted.

Rene Leriche first suggested in 1917 that an obliterated artery is no longer an artery since it carries no blood, but must be considered a plexus of sympathetic nerves in an abnormal state. The process of obstruction constantly exerts a stimulator effect upon the entire sympathetic segment of the involved artery. This reduced blood flow maintains viability of the extremity, but renders it functionally deficient. He pointed out that excision of the occluded segment obviously does not change the obstructed path of conduction for the blood flow. But when excision is done, certain extremities often lose their trophic changes and become more comfortable and functionally more useful limbs.

A series of cases was studied to determine whether an obstructed artery may initiate impulses which further impair the arterial circulation and to what extent arteriectomy may be of benefit. All cases of arterial insufficiency were studied in order to establish criteria for the selection of those cases suitable for arteriectomy. Visualization of the arterial tree was done on all patients as part of the vascular study. Those patients in whom occlusions of major vessels were demonstrated were selected for arteriectomy. If there were changes in the vessels of the extremity without obstruction, arteriectomy was obviously not performed. With increasing experience it became evident that only certain limbs responded well to arteriectomy alone, while others required adjuvant procedures or were found to be unsuitable for any sympathetic or vascular surgery.

It was noted that some of these extremities had had conservative treatment such as vasodilating drugs and alternating vacuum and pressure boots and that some had had ganglionectomies with or without peripheral nerve sections. Even though there had been no alteration of the trophic changes, there was marked benefit when an occluded segment of artery was demonstrated and excised. Those patients in whom a single major arterial obstruction was found and who had adequate collateral bridging of the defect and showed no associated organic or spastic obliterations responded best of all to arteriectomy alone. Those patients who had in addition to major vessel obliteration associated spastic obliterations required ganglionectomy. Those extremities which had obstruction of a major vessel but which also had obliterations of the smaller vessels of the leg or foot, even when a rich collateral supply was present, were found not suitable for arteriectomy, because the disease had progressed too far for this procedure. When extensive plaquing of the vascular tree was found, especially in the vessels of the leg, then ganglionectomy afforded at best only a moderate degree of relief

from pain. Poor collateral circulation indicated closures of these channels and such extremities came to amputation regardless of any type of treatment.

Experience has shown that obstruction of the femoral, popliteal, anterior or posterior tibial arteries by means of arteriectomy gives highly satisfactory results, providing, of course, the remainder of the vascular tree is in good condition. It is surprising how many patients will satisfy the criteria required for selection. Where arteriectomy is feasible, it produces far less shock to the elderly patient than the surgically more extensive procedure of ganglionectomy. The results were evaluated by the amount of regression of the trophic changes, the amelioration of claudication, and the increase of functional capacity of the extremity as measured by the distance the patient could walk. Lack of facilities prevented the rigid control of environmental temperature in dermathermic studies. However, it was demonstrated that there was a significant rise in surface temperature following arteriectomy.

Excision of the stimulator factor by arteriectomy removes the 3 components of the sympathetic nerves: (1) those fibers derived from the ganglionic trunks, (2) those fibers accompanying the somatic nerves and which are given off to the arteries at various levels, and (3) an intramural neurone complex. The first two components lie in the periarterial sheath and the last in the true wall of the artery. It can be understood then, that although a ganglionic trunk resection may be done, the stimulator factor within the artery can still produce vasoconstriction through its effect on the intramural neurone component.

One must know, then, whether major vessels are patent or obstructed and see the actual development of the collateral vessels. To this end, arteriography is employed to visualize the presence, location and extent of the obstruction. Resection of the entire obliterated segment by arteriectomy, carefully preserving functioning collaterals, is then done in the suitable cases. This produces vasodilatation and opens the vascular tree to its full capacity and restores a greater quantity of blood to the tissues of the extremity. (Geriatrics, January-February '51, N. Shnayerson)

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Streptomycin Dermatitis: In the clinical use of streptomycin there are reports of dermatitis developing in professional and technical staffs whose duties expose them to preparation of streptomycin for administration to patients or to handling glassware and other equipment contaminated with streptomycin. As similar problems may be encountered in the manufacture of streptomycin, a summary of experience gained over a period of 2 years may be of interest.

In the manufacture of streptomycin it was found that dermatitis developed in a certain number of individuals who handled this antibiotic. Dermatitis did not

occur among those who were employed in the fermentation process; it was found only among those engaged in handling the dried purified powder and in those in contact with solutions of streptomycin. It was thus clear that only those whose duties provided close contact with streptomycin developed dermatitis. It was found that dermatitis developed only on the exposed parts of the body, and in the following order of frequency: (1) the hands and forearms, (2) the neck and collar area, and (3) the eyelids. One employee developed attacks of sneezing and rhinorrhea if exposure to streptomycin powder in the atmosphere took place.

In filling vials by hand with streptomycin the employee sat on a chair, dressed in a sterile gown, her hands in sterile rubber (surgical) gloves. The hands and forearms were introduced through an aperture in a rubber cuff into a small sterile cubicle, and manipulation of the drug was done in the cubicle. While this provided a bacteriologically sterile streptomycin product, in a few employees dermatitis developed in the flexures of the elbows or on the forearms. This was ultimately found due to streptomycin powder working through the cotton sleeves of the gown, and coming in direct contact with the skin. Individuals who perspired heavily developed dermatitis more easily; moisture seems to facilitate development of dermatitis.

Dermatitis developed on the hands, in the glove area, in employees with excellent personal sterile technic. This was ultimately shown to be due to improper washing of the gloves, and was overcome by rinsing the gloves in running water, first on one side, then reversing them, and on the other; and by alkalinizing the washing solution. Dermatitis about the neck was always due to gross carelessness of the employee in handling a contaminated gown, or needless exposure to streptomycin.

There are certain operations concerned with the analysis of specimens of streptomycin which cannot readily be done by technicians wearing gloves. Among this small group, dermatitis of the eyelids occurred in 3 instances. In none of these did dermatitis of the hands, or any other part of the body, occur. It was shown that the dermatitis of the eyelids was due to putting fingers contaminated with streptomycin to the eyes; on controlling this habit, the dermatitis disappeared although the individual continued to perform the same technical duties. Persons engaged in washing or cleansing equipment contaminated with streptomycin were found to require a high degree of carefulness in protective measures. Solutions of streptomycin, if allowed to splash repeatedly over the unprotected skin, proved a rapid means of sensitizing the skin. It is believed that it is on account of the moisture naturally present about the eyes that dermatitis so readily develops on the lids.

During a period of 2 years, 101 persons were engaged in processes affording possibility of intimate contact with streptomycin. Twenty-one of these developed dermatitis; all had patch tests positive to streptomycin. Blood from 5 women with frank streptomycin dermatitis was withdrawn and used in passive transfer tests.

None of these specimens, in the donor sites, showed any reaction to streptomycin patch tests.

Difficulty was first encountered in having individuals accept the fact that bacteriologically sterile equipment could still carry dermatitis-producing substances in significant amount. With the ultimate satisfactory demonstration of this point, dermatitis disappeared among the employees. In no case did dermatitis due to streptomycin persist for more than 2 weeks following withdrawal from contact. Individuals with a history of previous allergic manifestation did not appear more prone to develop sensitivity to streptomycin than nonallergic individuals. No person developed streptomycin dermatitis who did not have a positive patch test. Thorough indoctrination of the factors leading to dermatitis has resulted in disappearance of the condition. Some cases of dermatitis ascribed to streptomycin are not due to streptomycin at all, and the diagnosis of streptomycin dermatitis should not be considered established without a positive patch test.

The question of whether the development of dermatitis due to streptomycin precludes the parenteral use of streptomycin for therapeutic reasons naturally arises. The absence of circulating antibodies in cases of contact dermatitis, within the limitation of patch testing, has been shown. In a series of 20 cases under active treatment with streptomycin, for tuberculosis at the Royal Edward Laurential Hospital in Montreal, none were found to have positive patch tests.

Simon reported patch-testing a group of 66 patients who had been treated with streptomycin. Only 2 reacted positively with patch test; 1 of these was in a group of 11 who discontinued treatment because of toxic reaction; neither of these patients suffered from skin manifestations.

The author believes that dermatitis due to streptomycin never develops except upon direct (skin) contact, and that withdrawal from contact leads to recovery promptly. The author has no information upon the length of time required to produce streptomycin skin sensitivity. One person developed dermatitis of the hands after 3 weeks in the department; others after 1 year; and 80 percent, many with continuous service in the same department for nearly 3 years, never developed any dermatitis.

Apart from dermatitis due to external contact, sensitivity of a more general and clinically more serious, type may occur. One woman member of a small group developed asthma on entering the room where streptomycin was subdivided. The atmospheric content of streptomycin was not determined, but it must have been minute. Her skin patch test was posivite. Follow-up could not be done. (J. Allergy, January '51, H. S. Mitchell)

* * * * * *

From the Note Book

1. Captain L. H. Roddis, MC, USN (Ret.), has just written a book entitled "James Lind, Founder of Nautical Medicine." Doctor Lind is shown to have been a pioneer in many phases of naval medicine. The book is excellent reading for those interested in the history of naval medicine and in the early attempts made to overcome some of the diseases prevalent in his time. The book is published by H. Schuman, Inc., New York.

2. The 40 most promising young scientists in America's high schools were chosen by a panel of judges after a nation-wide competition in which top-ranking seniors in all public, parochial and private schools in the continental U. S. were invited to participate. Entrants totaled 13,638. The 40 winners, 15 to 17 years of age, 10 girls and 30 boys, will participate in the Science Talent Institute and compete for $11,000 in Westinghouse Science Scholarships. (Science News Letter, 10 February '51)

3. The health services of the Civil Defense Administration will probably be organized with Colonel W. L. Wilson, MC, USA, as assistant administrator in charge of the Office of Health and Welfare. Under him there will be 2 divisions, Health Services and Special Weapons Defense under Dr. N. C. Kiefer and Emergency Welfare under Mr. R. Schaeffer. CDA is charged with coordinating civilian medical preparations for an atomic attack or other major disaster and with stockpiling medical supplies, drugs and surgical equipment. CDA will publish about the end of February a layman's pamphlet on what to do in case of biologic warfare attack. (Washington News, J. A. M. A., 17 February '51)

4. A "Medical Defense Plan of a Metropolitan Area" is discussed in the J.A.M.A., 17 February 1951, by F. F. Schade.

5. A discussion of the "Diagnosis of Coronary Artery Disease," particularly in aviation personnel, appears in Journal of Aviation Medicine, December 1950. (G. H. Marquardt et al.)

6. A new hand-operated map reproduction device capable of making 200 copies of four-color maps in sizes up to 22 x 29 inches has been developed by the Engineer Research and Development Laboratories, Ft. Belvoir, Va. (PIO, Dept. Defense, 5 February '51)

7. "The Management of Fibromyomata Uteri" is discussed in the American Journal of Obstetrics and Gynecology, January 1951. (C. H. Manzy et al.)

8. A review of recent literature concerning the lids, lacrimal apparatus and conjunctiva appears in the A.M.A. Archives of Ophthalmology, January 1951. (J. H. Allen)

9. Student representatives from 47 medical schools in the United States met on 28 and 29 December 1950 in the headquarters offices of the AMA, Chicago, for the expressed purpose of drafting a constitution for and the organizing of a Student American Medical Association. (J. A. M. A., 10 February '51)

10. "Disorders of the Cardiovascular System Occurring with Catheterization of the Right Side of the Heart" is discussed in American Heart Journal, February 1951, by W. T. Zimdahl.

11. In treating typhoid carriers, a recent report indicates that the best results were obtained with an aqueous suspension of a typhoid inhibiting, Gram-positive, spore-forming bacillus resembling Bacillus subtilis. When such a suspension was fed to each of 25 carriers, 19 were cured. The 6 failing to obtain relief were biliary carriers. (GP, February '51, from an article by J. A. Vaichulis et al. in August 1950 Annals of Internal Medicine)

12. "The Partition of Radiophosphorus (P^{32}) in Blood, Urine and Tumor Tissue in Patients with Hodgkin's Disease and Lymphosarcoma Before and After Treatment with Nitrogen Mustard" appears in the Journal of the National Cancer Institute, October 1950. (S. P. Masouredis et al.)

13. America's pipelines for petroleum products now have a total length of nearly 153,000 miles. (Science News Letter, 10 February '51)

14. A contract has been negotiated between ONR and the Dental School, University of Pennsylvania, for a joint study with the Naval Medical Research Institute on the "Oral Effects of Ionizing Radiation." That portion of the study conducted at NMRI is supported by BuMed Research Funds, with personnel made available by the Dental Division, BuMed.

15. The Bureau of Medicine and Surgery has recently made research funds available to the Library of Congress for search of the foreign literature on all phases of oral bacteriologic research having practical clinical application in support of the study being conducted in the Dental Division, Naval Medical Research Institute.

* * * * * *

Medical Aspects of Nuclear Energy Course: The Chief, Army Field Forces, has allocated a quota for 5 medical officers of the Navy or Naval Reserve to attend an indoctrination course in Medical Aspects of Nuclear Energy to be given 14-18 May 1951 at the Army Medical Department Research and Graduate School, Army Medical Center, Washington, D. C.

Medical officers on active duty who desire to attend the course should apply to the Chief of the Bureau of Medicine and Surgery. Applications will be processed

in order of receipt and authorization orders ONLY provided for those officers approved to attend the course. (Professional Div., BuMed)

* * * * * *

General Postgraduate Course for Dental Officers, U. S. Naval Dental School, National Naval Medical Center: On 3 January 1951, 16 officers reported to the Naval Dental School for the first general postgraduate course of the calendar year. The course consists of 26 weeks of instruction; graduation is scheduled for 29 June 1951.

Organization of the Postgraduate Course. In order to provide one-half or one full semester hour's credit, 16 lectures or multiples, or 1/4 or 1/2 fraction are being given in major subjects taught. Additional periods are provided in each subject for seminars and examination. Laboratory and clinic periods which supplement formal lectures are scheduled as soon as possible following the related classroom instruction. Organized laboratory courses are given in conjunction with the lectures in oral pathology and bacteriology. Clinical practice is provided in clinical assignments which include (1) operative dentistry and airbrasive, (2) prosthodontia (full and partial denture), (3) crown and bridge. Clinical practice is also provided in rotating assignments which include (1) oral surgery and roentgenology, (2) oral diagnosis and blood collecting, (3) endodontia, and (4) periodontia.

In addition to the laboratory work essential to the clinical practice, separate laboratory technic courses are provided in the fields of full denture, partial denture, crown and bridge, and occlusion adjustment necessary to periodontial treatment.

In order to enable dental officers to serve as qualified First Aid Instructors, the general course includes the following American Red Cross First Aid Training: (1) standard course, (2) advanced course, (3) instructor's course.

A research project is assigned to each postgraduate officer during the second month of the course. One week is allotted to research laboratory work, during which full-time service of a civilian consultant is available. One week of the postgraduate schedule has been allotted to the course in Medical Aspects of Radioactive Isotopes conducted by the Naval Medical School.

General Postgraduate Course Schedule. Three lecture hours are provided daily Monday through Friday, except during those periods when laboratory or research projects are being done. Lectures in public speaking and first aid are given on Saturday mornings. The postgraduate class is divided into two sections which alternate between the various clinic, laboratory and rotation assignments. (Asst. Chief of Bureau for Dentistry)

NOTE: Refer to BuMed Circular Letter No. 51-19 of 26 January 1951, Medical News Letter, Volume 17, No. 4, page 30.

Qualifications of Civilian Nurses in Civil Service Employees' Occupational Health Services: The Industrial Health Program of the Navy, as set forth in NCPI 88, is based on: (1) U. S. Employees' Compensation Act of 1916, as amended, (NCPI 90); (2) Civil Service Regulations (NCPI 10); and Public Law 658 of the 79th Congress. Public Law 658 of the 79th Congress provides for employees' health service programs of a preventive type. Hiring of civilian nurses to replace Navy military nurses, currently being reassigned to urgent military billets, must be undertaken with full cognizance of special qualifications required of such nurses. Professional standards for nurses engaged in the Navy health service programs should be those established by the Civil Service Commission for personnel engaged in a preventive medical program.

Attention of all field Medical Departments planning to employ civilian nurses for duty in connection with the civilian industrial health program is directed to "Civil Service Circular No. 155, unassembled, issued 2 February 1949." This circular describes qualifications in effect for first level Public Health nurses. Education and experience in industrial plant nursing or in public health nursing is a requisite for nurses who are to function effectively in an occupational medical service of the caliber required by regulation, orders, and laws. The registered nurse with hospital training only will not be adequately qualified to assist the medical officer in conducting an employees' health service of the preventive type.

It is suggested that medical officers interested in employing nursing personnel for the civilian occupational medical service contact the Regional Civil Service Office for a copy of the Circular No. 155. It is probable that there will be no available register of qualified nurses in the areas. In absence of such eligibility list, a defense agency has authority to employ personnel for open billets. The Area Civil Service Office should be consulted in this matter. If it becomes necessary for the Medical Department to select a nurse without benefit of a Civil Service list of eligibles, it is urged that every effort be extended to procure a nurse with training and experience in industrial nursing.

In drawing up job description sheets, describing the functions and responsibilities of nurses in the industrial health program, the basic qualification requirements in the Civil Service Circular may be used as a guide. Reference in the Circular to "home-visits" should not be included in a job description sheet, since such service is not included in the Navy occupational health program. NCPI 88 will serve as a source for delineation of specific administration and professional functions. Any duties in connection with military personnel should be categorized.

It is appreciated that the transfer of military naval nurses with the resultant need for immediate replacement may have resulted in the employment of civilian nurses without benefit of the foregoing suggestions. In instances where no such qualified personnel are available, and it becomes necessary to employ a nurse with no industrial or public health nursing experience, it is urged that the

industrial medical officer establish a "program of indoctrination and training" for newly hired civilian nurses to insure their guidance and instruction in the "preventive phases" of Civil Service employees' health services. It is requested that Medical Departments forward copies of "job description sheets of civilian nurses" in effect at their activities to the Bureau of Medicine and Surgery, Attention: Industrial Health Section. (Preventive Med. Div., BuMed)

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List of Recent Reports Issued by Naval Medical Research Activities:

Naval Medical Field Research Laboratory, Camp Lejeune, N. C.

Photobiological and Photochemical Action of Nonionizing Radiation at Low Temperatures. I., Photochemical Studies on 1-Tyrosine, NM 005 052.13.03, January 1951.

Photobiological and Photochemical Action of Nonionizing Radiation at Low Temperatures. II., Preliminary Studies on Some Proteins and Organic Compounds, NM 005 052.13.04, January 1951.

Photobiological and Photochemical Action of Nonionizing Radiation at Low Temperatures. III., Photobiological Studies of E. coli-B, NM 005 052.13.05, January 1951.

Naval Medical Research Institute, NNMC, Bethesda, Maryland.

The Relative Susceptibilities of the Commonly Used Laboratory Mammals to Infection by Schistosoma mansoni, NM 005 048.02.25, 8 August 1950.

* * * * * *

Training Program for Naval Reserve Entomologists and Malariologists: Training courses of two weeks' duration for Naval Reserve entomologist and malariologist technicians are being conducted at the Navy Malaria and Mosquito Control Unit #1, U. S. Naval Air Station, Jacksonville, Florida. Classes convene on the first and third Wednesdays of each month.

This program is planned to bring to the Naval Reserve officers and men the latest information concerning the needs, methods, and operations of the Insect and Pest Control workers. This program will provide an opportunity for reserve personnel to receive two weeks' annual training duty in an area where insect control problems are encountered throughout the year.

Inactive Naval Reserve entomologist and malariologist technicians residing in the First, Third, Fourth, Fifth, Sixth, Eighth, and Ninth Naval Districts and the

Potomac River Naval Command, who desire to perform this annual training duty, should submit a request to the Commandant of their home naval district. (Reserve Div., BuMed)

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Course in Medical Aspects of Special Weapons and Radioactive Isotopes: The Bureau of Medicine and Surgery announces a course of instruction in Medical Aspects of Special Weapons and Radioactive Isotopes. This course is to be conducted by the Commanding Officer, U. S. Naval Medical School, at the National Naval Medical Center, Bethesda, Maryland. It is scheduled to convene on Monday, 21 May 1951 and continue to 26 May 1951.

The purpose of this course is to present problems likely to be confronted and technics to be employed by medical and dental officers in the field of radioactivity. The subjects will be presented by speakers of outstanding prominence in their specialties; hence, it is assured the presentation will be interesting and informative to all Medical, Dental, Medical Service Corps, and Nurse Corps officers.

This course is conducted primarily for the benefit of inactive Reserve Medical and Dental officers; however, a limited number of officers of the medical department on active duty may be given "Authorization Orders" (no expense to the government) in accordance with paragraph 3 of BuPers-BuSandA joint letter 50-362 NDB of 15 May 1950. Inactive Reserve Medical, Dental, Medical Service Corps, and Nurse Corps officers residing in the 1st, 3d, 4th, 5th, 6th, 8th, 9th naval districts and Potomac River Naval Command who desire to attend this course should submit their request for six days' training duty to the Commandant of their home naval district. All requests should reach the Commandant's office at the earliest practicable date. Meals and a limited number of sleeping quarters will be available for those officers who desire such accomodations.

It is desired to invite inactive Reserve personnel's attention to the fact that acceptance of orders to attend these courses WILL NOT, in any way, increase the possibility of involuntary recall to active duty of the personnel concerned. Therefore, inactive Reserve medical department personnel are encouraged to take advantage of this opportunity to attend this course on active training duty orders in a pay status. (Reserve Div., BuMed)

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JOINT LETTER

BUMED CIRCULAR LETTER 51-25
C2, SR 40-410-10
AFR 160-55B
(Changes No. 2)

Departments of the Army, the Navy, and the Air Force

12 February 1951

MEDICAL SERVICE

CENTRAL FACILITIES PROVIDED FOR DEPARTMENT OF DEFENSE BY ARMED FORCES INSTITUTE OF PATHOLOGY

SR 40-410-10, BuMed Cir Ltr No. 50-50 and AFR 160-55, 8 June 1950, is changed as follows:

4. Autopsy material and protocols.--The original protocol * * * suicide, accident, etc. If the death occurred outside of a hospital, a statement concerning the circumstances surrounding death will be included in the autopsy protocol in lieu of the clinical abstract. For the Army, this statement will be furnished by the investigating officer as prescribed by paragraph 19c(3) of AR 600-550; for the Navy, the medical officer who performs the autopsy will supply the necessary information; for the Air Force, a copy of Report of Investigation as provided in AFR 35-67 will be furnished.

9. Collection, preparation, and shipment of pathologic materials and related records.

* * *

b. Autopsy material.

* * *

(3) A complete autopsy protocol includes--

(a) An abstract of * * * copies of electrocardiograms. A clinical abstract in a stillbirth consists of a summary of the maternal history, prenatal history, labor record and such X-ray and laboratory examinations as may have been performed on the mother. A clinical abstract in a neonatal death consists of a summary of the maternal history, prenatal history, labor record, infant's history from birth to death, and such X-ray and laboratory examinations as may have been performed on mother and child. The placenta and umbilical cord will be submitted for pathologic examination in every stillbirth and whenever possible in neonatal death.

* * *

By order of the Secretaries of the Army, the Navy, and the Air Force:

Official:
EDWARD F. WITSELL
Major General, USA
The Adjutant General

J. LAWTON COLLINS
Chief of Staff, United States Army

Official:
CHARLES WELLBORN, JR.
Rear Admiral, USN
Deputy Chief of Naval Operations
(Administration)

H. L. PUGH
Acting Chief of the Bureau of Medicine and Surgery
Department of the Navy

Official:
K. E. THIEBAUD
Colonel, USAF
Acting Air Adjutant General

HOYT S. VANDENBERG
Chief of Staff, United States Air Force

The above letter will not be printed in the Navy Department Bulletin.

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JOINT LETTER

BUMED CIRCULAR LETTER 51-26 8 February 1951

From: Chief, Bureau of Medicine and Surgery
Chief, Bureau of Supplies and Accounts
To: All Hospital Ships

Subj: Subsistence of patients on board hospital ships

Ref: (a) BuMed-BuSandA Joint ltr of 1 Jul 45 (BuMed C/L No. 45-174)
(b) BuMed C/L No. 50-58
(c) BuSandA Manual, Par. 54102.4

1. Reference (a) is canceled and superseded by the instructions contained in this letter.

2. The following policies and procedures are prescribed for the subsistence of patients on board hospital ships.

a. The following personnel on board hospital ships shall be subsisted from the naval hospital diet kitchen:

(1) All patients who require special diets (as determined by the officer in command of the naval hospital).

(2) All officer patients and other patients in officer status.

(3) All enlisted personnel assigned exclusively to duty in the naval hospital diet kitchen.

b. Subject to working arrangement between the supply officer and the officer in command of the naval hospital, cooked rations shall be requisitioned from the general mess as the basis for the prescribed special diet. For accounting and reporting purposes, such rations furnished the naval hospital shall be converted to their component items of provisions and invoiced on NavSandA Form 127, Receipt/Expenditure Invoice accordingly. These rations may be supplemented by such items as may be prescribed by the officer in command of the naval hospital, procurement of which may be effected either by requisition on supply officer's stock or from commercial sources under authority of the Medical Department Annual Sundry Purchase Requisition.

c. Reimbursement to the appropriations "Navy Stock Fund" and "Military Personnel, Navy", for the value of cooked rations furnished to the naval hospital diet kitchen which are converted to component items of provisions in accordance with subparagraph (b) will be effected in the following manner:

(1) Navy Stock Account returns - charge to appropriation "Medical Care, Navy" will be effected on Materials Summary submitted by the hospital ship.

(2) NavSandA 45, Ration Record - charge to appropriation "Medical Care, Navy" and credit to appropriation "Military Personnel, Navy" will be effected by the Bureau of Supplies and Accounts on the basis of information derived from the audit of the NavSandA 45, Ration Record.

d. Public Vouchers prepared in payment of invoices for special diet items procured under authority of the Medical Department Annual Sundry Purchase Requisition shall be drawn directly under the appropriation Medical Care, Navy. Items of provisions for use in special diets procured from supply officer's stock will be charged to the appropriation Medical Care, Navy, Expenditure Account 13216, and local allotment.

e. Reimbursement to the appropriation "Medical Care, Navy" for subsistence furnished Navy and Marine Corps enlisted personnel from the naval hospital diet kitchen will be effected by the Bureaus from the number of subsistence days reported on the NavMed 36, Ration Record, prepared and submitted in accordance with reference (b) and these instructions.

f. All enlisted patients and other patients in enlisted status who do not require special diets (as determined by the officer in command of the naval hospital) shall be subsisted in general mess. The supply officer shall report the subsistence of such personnel on his Provision Return. The officer in command of the naval hospital shall report these patients as "not subsisted" on his NavMed 36, Ration Record.

g. The officer in command of the naval hospital shall furnish the executive officer and the supply officer of the ship a daily report of the number of personnel subsisted from the naval hospital diet kitchen, by classification as listed in reference (b), in order that these personnel may be excluded from the NavSandA 27, Ration Memorandum; NavSandA 27A, Daily Ration Memorandum; and the NavSandA 45, Ration Record, or the Return of Provisions (S. and A. Form 36).

h. Checkages for subsistence furnished Navy and Marine Corps Officer patients shall be effected in accordance with reference (c).

i. Local collections for subsistence furnished personnel reported as "subsisted" on Lines 28, 29, 30, 31, 45, and 49 of NavMed 36, Ration Record shall be made at the rate established periodically by the Secretary of the Navy as the value of the hospital ration, and such funds shall be deposited with the disbursing officer for credit to the appropriation Medical Care, Navy.

H. L. Pugh C. W. Fox

The above letter will not be printed in the Navy Department Bulletin.

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BUMED CIRCULAR LETTER 51-27 8 February 1951

From: Chief, Bureau of Medicine and Surgery
To: Commandants Naval Districts, Continental United States
Commanders Naval Training Centers
Commanding Generals Marine Corps Barracks
Commanding Officer, Naval Training Station, Newport, Rhode Island
Superintendent Naval Academy, Annapolis, Maryland

Subj: Tuberculin-testing of Navy and Marine Corps personnel

Ref: (a) BuMed Circular Letter No. 47-91 of 16 July 1947
(b) BuMed Circular Letter No. 48-6 of 19 Jan 1948

1. References (a) and (b) are hereby canceled and superseded.

2. A tuberculin test shall be made of all Navy and Marine Corps personnel as soon as practicable after reporting to the training activities addressed, in accordance with provisions of paragraph six below.

3. The "Single Test" tuberculin test material is available for issue at the Naval Medical Supply Depots, Edgewater, New Jersey and Oakland, California, only to those training activities addressed, who are authorized to administer the tests to recruits.

4. A record of all such tests shall be maintained and reported to this Bureau, Code 7212, after the end of each calendar year giving the number tested and the number of negative reactions, doubtful reactions, and of +, ++, +++, ++++, reactions, respectively.

5. The results of the test shall be entered in the Health Record on NavMed-H-3 under "Other Inoculations". The entry shall contain the place and date of test, the fact that 0.0001 mgm. was used, the result in plus marks as indicated above, if positive, or as "doubtful" or "negative" as the case may be. The entry shall be signed by the individual responsible for the performance and interpretation of the test.

6. The Tuberculin Test

a. Materials. -- (Stock numbers are from the Armed Forces Catalog of Medical Materiel.)

(1) Purified protein derivative test kits -- Stock No. 1-613-975, 50-test size; or Stock No. 1-613-980, 250-test size. Shall be prepared according to directions in the kit. Solutions shall be stored in the refrigerator (not frozen) for not longer than four days, after which they must be discarded. When properly prepared, each 1/10 cc. test dose contains 0.0001 mgm. PPD.

(2) Syringes - Stock No. 3-802-800. Shall have been used for no other purpose, and shall be tightly fitted, chemically clean and sterile. They may be re-used, with proper precautions as to cleanliness and sterility, for these tests or other purposes. Once used for any other purpose, however, they shall not again be used for these tests.

(3) Needles - Stock No. 3-496-400. A chemically clean and sterile needle which has been used for no other purpose shall be used for each test. Needles may be re-used for these tests, after cleansing and sterilizing, if they have not been used for any other purpose.

(4) Ordering -- Each training activity addressed when ordering the above items shall certify on the face of NavMed-4 that requisitioning activity has been

authorized to administer "Single Test" tuberculin tests. It is recommended that, wherever possible, the 250-test package be used. Orders for the tuberculin test packages, syringes, and needles required for this program should be carefully planned because overstocking in any one activity may hamper the program at all others. Items should be ordered and reordered only in quantities sufficient to equal the planned usage rate for the next six months. If, for any reason, it becomes apparent that an excess of any of the tests, syringes, or needles has developed, the excess should be promptly returned to the nearest medical supply depot if suitable for reissue.

b. Technique

(1) The testing and interpreting shall be performed by a medical officer or by adequately trained personnel of the Hospital Corps under the supervision of a medical officer. Following aseptic preparation of the skin an intradermal injection of one-tenth cubic centimeter of the tuberculin solution shall be made upon the volar aspect of the left forearm. (The point of the needle should be plainly visible just within the outer layers of the epidermis.) The result, immediately after injection, should be a definite wheal, pale and sharply demarcated. Great care must be exercised to avoid subcutaneous injection.

NOTE: When reading the tuberculin test, the forearm should be in a good light and flexed a little at the elbow. Tautness of underlying muscles may be sufficient to obliterate the redness and edema. It is well, also, to look across the forearm rather than down upon it. Pass the finger over the test area; the induration caused by the edema can be felt even when it does not produce an elevation that can be seen.

c. Result of Test

(1) The test shall be examined after an interval of not less than forty eight hours or more than seventy two. It should be palpated for the presence of edema. Both redness and edema should be present, and the diameter should be carefully measured with a millimeter scale. Reactions are to be graded +, ++, +++, ++++, "doubtful", or "negative", as follows:

(+) redness and definite edema, more than five mm. and not exceeding ten mm. in diameter.

(++) redness and edema measuring from one-two cm. in diameter.

(+++) redness, edema, exceeding two cm. in diameter.

(++++) redness, edema, and an area of necrosis.

(Doubtful) A reaction with slight redness and a trace of edema, measuring 5 mm. or less in diameter is to be recorded as "doubtful".

(Negative) If there is no edema at the site of injection, even if redness is present, the test is to be recorded as "negative".

7. All persons administering tuberculin tests are cautioned that the "Single Test" prescribed for this program should not be used for any other tuberculin tests. ("Single Test" tuberculin tests are five times as potent as the usual "First Test" tuberculin test, and one-fiftieth as potent as the "Second Test" tuberculin test).

H. L. Pugh

The above letter will not be printed in the Navy Department Bulletin.

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JOINT LETTER

BUMED CIRCULAR LETTER 51-28 12 February 1951

From: Chief of Naval Personnel
Chief, Bureau of Medicine and Surgery
To: All Ships and Stations

Subj: Final Physical Examination of Candidates for Admission to the U. S. Naval Academy

1. Final physical examination of civilian candidates for admission to the U. S. Naval Academy shall be performed by boards of medical examiners in May of each year and at such other times as may be necessary, at the following activities:

U. S. Naval Hospital, Chelsea, Mass.
U. S. Naval Hospital, St. Albans, Long Island, N. Y.
U. S. Naval Hospital, Philadelphia, Pa.
U. S. Naval Dispensary, U. S. Naval Academy, Annapolis, Md.
U. S. Naval Hospital, Portsmouth, Va.
U. S. Naval Hospital, Charleston, S. C.
U. S. Naval Hospital, Memphis, Tenn.
U. S. Naval Hospital, Pensacola, Fla.
U. S. Naval Hospital, Key West, Fla.
U. S. Naval Hospital, Jacksonville, Fla.
U. S. Naval Hospital, Corpus Christi, Texas
U. S. Naval Air Station, Dallas, Texas
U. S. Naval Hospital, Great Lakes, Ill.

U. S. Naval Air Station, Olathe, Kansas
U. S. Naval Air Station, Denver, Colo.
U. S. Naval Hospital, San Diego, Calif.
U. S. Naval Hospital, Oakland, Calif.
U. S. Naval Hospital, Bremerton, Wash.
Naval Unit, Tripler General Hospital, Honolulu, T. H.
U. S. Naval Hospital, Coco Solo, C. Z.

2. The U. S. Naval Hospital, Newport, Rhode Island, shall provide similar service to the service source candidates at U. S. Naval School, Academy and College Preparatory, U. S. Naval Training Center, Newport, Rhode Island, upon completion of training of candidates at that school.

3. Additional Medical Corps personnel will be furnished, on temporary additional duty basis, at the appointed time, to the U. S. Naval Air Station, Olathe, Kansas, from the U. S. Naval Hospital, Memphis, Tennessee; to the U. S. Naval Air Station, Dallas from the U. S. Naval Hospital, Corpus Christi, Texas; and to the U. S. Naval Air Station, Denver, Colorado from the U. S. Naval Hospital, Oakland, California.

4. Candidates shall be examined in accordance with existing physical requirements for admission to the U. S. Naval Academy, and requests or recommendations that physical defects be waived shall not be submitted.

5. The Senior Member of the Board of Medical Examiners at each activity named in Paragraphs 1 and 2 above shall be responsible for the examination procedure and correctness of reports of physical examination.

6. In the interest of consistency, two members from the Permanent Board of Medical Examiners, U. S. Naval Academy, one of whom will be a dental officer, shall be detailed to each of the above named activities, on temporary additional duty basis, at the appointed time of examination at each activity, to assist the Senior Member of the local Board of Medical Examiners in reviewing reports of physical examination and medical history, to afford counsel in cases which are not clearcut, and to resolve differences of professional opinion on individual candidates, when necessary.

7. The President of the Permanent Board of Medical Examiners at the U. S. Naval Academy shall:

(a) Inform the Bureau of Medicine and Surgery of the number and qualifications of medical officers needed to reinforce the staffs of the U. S. Naval Air Stations at Olathe, Kansas, Denver, Colorado, and at Dallas, Texas, and of the time their services will be required, not less than three weeks prior to the time of examinations at one of those activities.

(b) Provide the Bureau of Naval Personnel (Naval Academy Branch) and the Bureau of Medicine and Surgery a tentative schedule of dates for convening Boards of Medical Examiners at the several examining centers.

8. The Bureau of Naval Personnel (Naval Academy Branch) will inform each of the examining centers of the dates on which final physical examinations for admission to the U. S. Naval Academy will be held. The names and number authorized to appear each day will also be furnished. The maximum number of candidates per day authorized to appear at examining centers, except the U. S. Naval Academy, shall not exceed approximately fifty. No more than one hundred and fifty candidates per day shall be authorized to appear before the Permanent Board of Medical Examiners at the U. S. Naval Academy.

9. (a) The results of final physical examination for admission shall be reported upon Standard Form 88 in duplicate, and on Standard Form 89 in the applicant's handwriting, in duplicate, in every instance.

(b) For candidates who are accepted, Forms NavMed H-2 and NavMed H-4 shall be opened, in duplicate.

(c) All reports (Standard Form 88 and 89 in duplicate, Forms NavMed H-2 and H-4 in duplicate in the case of all accepted candidates; and Standard Form 88 and 89 in the case of rejected candidates) shall be forwarded directly to the President, Permanent Board of Medical Examiners, U. S. Naval Academy, Annapolis, Maryland. Prompt submission of all reports is directed.

10. The candidate shall be informed, by the Senior Member, Board of Medical Examiners, of the results of the final physical examination for admission, and the decision of the Board shall be final when resulting in the acceptance of the candidate. Rejection of a candidate completes all action in his case, insofar as the Board is concerned. However, a rejected candidate shall be informed by the Senior Member, Board of Medical Examiners that he may request a reexamination by the Board of Medical Review at the U. S. Naval Academy under the conditions outlined in Paragraph 11. Responsibility for initiating such a request shall rest with the rejected candidate and all requests for physical reexaminations shall be submitted in writing prior to 1 June to the Bureau of Naval Personnel, Navy Department, Washington 25, D. C., marked "Attention, Naval Academy Branch." The Bureau of Naval Personnel will notify rejected candidates who request reexamination of the time and date upon which they should appear at the U. S. Naval Academy.

11. Rejected candidates appearing at the U. S. Naval Academy for reexamination and final disposition as their physical qualifications shall do so at their own expense. The primary purpose of the provision for a reexamination at the U. S. Naval Academy is to afford candidates with remedial defects which caused their

rejection an opportunity to have such defects corrected and for reexamination thereafter. Such opportunity for further examination does not imply ultimate acceptance. Candidates with other than remedial defects may also be reexamined, at their own expense, by the Board of Medical Review at the U. S. Naval Academy. In all instances of reexamination, the decision of the Board of Medical Review shall be final.

12. Upon completion of enrollment of a class at the U. S. Naval Academy, the Permanent Board of Medical Examiners shall forward to the Bureau of Medicine and Surgery Standard Forms 88 and 89, and completed forms NavMed H-2 and NavMed H-4 for each man enrolled, the face of the Standard Form 88 to show the superscript, "Enrolled, U. S. Naval Academy" and the date thereof. All reports on candidates rejected shall be forwarded to the Bureau of Medicine and Surgery for record purposes.

13. Each candidate shall execute a sworn statement as required by Paragraph 2115.10(c) Manual of the Medical Department.

14. Nothing in this letter alters or cancels any provision of Paragraph 2115, Manual of the Medical Department, for preliminary physical examination of candidates for appointment to the U. S. Naval Academy.

J. W. Roper H. L. Pugh

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BUMED CIRCULAR LETTER 51-29 13 February 1951

From: Chief, Bureau of Medicine and Surgery
To: All Ships and Stations

Subj: Medical care of foreign military personnel assigned to full time duty in the North Atlantic Treaty Organization

Ref: (a) Par 4162, MMD, 1945

1. Foreign military personnel assigned to full-time duty with the North Atlantic Treaty Organization are eligible for medical care within the provisions of reference (a).

2. North Atlantic Treaty Organization member countries are as follows: Belgium, Canada, Denmark, France, Iceland, Italy, Luxembourg, Netherlands, Norway, Portugal and the United Kingdom.

3. Naval medical facilities providing hospitalization for subject personnel will submit DD Form 7, "Report of Treatment Furnished Pay Patients, Hospitalization

Furnished (Part A)", monthly for each member country reported, in quintuplicate. Category of patient shall be shown as "Foreign Military Personnel, NATO". NavMed 36, Ration Record shall report this classification of patient on Line 66, with appropriate analysis under "Remarks".

H. L. Pugh

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BUMED CIRCULAR LETTER 51-30 14 February 1951

From: Chief, Bureau of Medicine and Surgery
To: CO NNMC Bethesda, Md.
CO's all U. S. Naval Hospitals

Subj: Maintenance Division; designation of

Ref: (a) Chapter 11, Manual of the Medical Department, 1950

1. It has come to the attention of the Bureau that several naval hospitals are using the title "Public Works Division" or "Public Works Department" to designate that administrative division which is responsible for maintenance functions. Reference (a) provides an approved plan of organization for naval hospitals, from which it will be noted that the designation for this division of a naval hospital is "Maintenance Division."

2. Those naval hospitals which have been using the title "Public Works Division" or "Public Works Department" shall take immediate steps to redesignate the division as "Maintenance Division" in consonance with reference (a).

H. L. Pugh

The above letter will not be printed in the Navy Department Bulletin.

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BUMED CIRCULAR LETTER 51-31 14 February 1951

From: Chief, Bureau of Medicine and Surgery
To: All Ships and Stations having Dental Personnel

Subj: Dental Prosthetic Technicians; training of

Ref: (a) Catalog of Dental Technician Schools and Courses (NavMed P-1309)

1. In order to provide the naval dental service with an adequate number of trained Dental Prosthetic Technicians who will be competent to fulfill the descriptions of

job requirements in the Manual of Enlisted Navy Job Classifications, personnel of the Dental Rating Group in pay grades E-2, E-3, E-4 and E-5 only will be considered for assignment to this training in the future. Minimal qualifications are as follows:

(a) Must be a volunteer (mandatory)
(b) Must be recommended by a dental officer (mandatory)
(c) Must be a Dental Technician, General (mandatory)
(d) Manual dexterity
(e) Mechanical aptitude

2. Due to the highly technical nature of this training, personnel recommended should be screened very carefully to insure that they possess the necessary qualifications. All of the above listed minimal qualifications are not mandatory since it is obvious that no definite dexterity or aptitude standards for the selection of such candidates can be established. However, it is believed that the attrition rate during the training period because of inaptitude can be greatly reduced if the candidates are carefully screened with the view toward fully meeting the minimal qualifications enumerated in paragraph 1.

3. In accordance with reference (a), recommendations from dental officers who examine candidates for training should be submitted to the appropriate district or staff headquarters where they will be considered by the district or staff dental officer for filling assigned quotas. Districts and staffs not receiving a sufficient quota proportionate to available candidates should request an increase in quota; conversely a reduction in quota should be requested when the assigned quota is too large. In no circumstance should candidates be assigned purely for the purpose of filling a quota when it is apparent that they do not meet the minimal aptitude requirements, or do not volunteer for the training.

4. It is desired that the contents of this circular letter be made known to all dental personnel.

H. L. Pugh

The above letter will not be printed in the Navy Department Bulletin.

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BUMED CIRCULAR LETTER 51-32 15 February 1951

From: Chief, Bureau of Medicine and Surgery
To: Commanding Officers All Naval Hospitals

Subj: Restriction of assignment of Officers of the Nurse Corps to only those duties which require professional training

1. While the trend of all forward looking employing agencies is to make use of the highest skills of their employees a disposition has been noted in some naval hospitals to assign Officers of the Nurse Corps to duties which require no professional training, such as linen room and housekeeping details. This policy could have a disastrous effect on the procurement program of the Navy to obtain nurses should the public become aware of this practice.

2. The shortage of professional nurses is so critical as to cause national concern and the Navy faces keen competition in its effort to procure them. So far we have received splendid cooperation from all schools of nursing and the public in general. We wish to continue to merit continuing support.

3. It is directed that Officers of the Nurse Corps will be regularly assigned only to those duties for which they were commissioned, that is the administration of the nursing service and the professional care of the sick.

H. L. Pugh

The above letter will not be printed in the Navy Department Bulletin.

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BUMED CIRCULAR LETTER 51-33 16 February 1951

From: Chief, Bureau of Medicine and Surgery
To: Holders of Bulletin of BuMed Circular Letters

Subj: August 1950 revision of Standard Form 88 (Report of Medical Examination) and 89 (Report of Medical History), use of

Ref: (a) BuMed Circular Letter 48-103 of 23 Sept 1948
(b) Chapter 15, Manual of the Medical Department (to be printed)

1. Reference (a) is cancelled.

2. Standard Forms 88 and 89 shall be prepared in accordance with directive contained in Section VII of reference (b). Until such time as reference (b) is promulgated, current directives pertaining to the use of the subject forms continue in effect. As existing stocks of the old forms are exhausted, the revised Standard Forms will be issued upon requisition.

3. No major changes were made in the form or content of Standard Form 89. The item which the individual signs certifying to the completeness and veracity of answers given, has been modified somewhat, and an item pertaining to the gynecological history of females has been added. The physician's summary and elaboration of pertinent data (item 40) is particularly important when the report is

reviewed. Therefore, the medical officer shall comment sufficiently on the more significant answers given by the examinee in the medical history. This will obviate the necessity for returning the form for completion of item 40.

4. Standard Form 88 has been considerably modified. Except for items where specific measurements or laboratory data are to be entered, it is in effect a time-saving, check-off list. However, ample space has been provided for recording defects and abnormalities. All defects and deviations from the normal shall be reported and described in full detail. Care should be taken to definitely indicate in each case, under remarks of item 44 DENTAL, whether or not the person examined meets the dental standards for the purpose of the examination.

5. Reference (b), when promulgated, will no longer require that applicants or candidates for enlistment or appointment meet minimum chest-expansion and chest-measurement standards. Accordingly, chest measurements need no longer be entered on Standard Form 88.

6. Item 39 (identifying body marks, scars, tattoos) was added to Standard Form 88 in order that, at some future date when the Health Record is revised, the form could be used in lieu of the present NavMed H-2. Until such time as the present Health Record is revised, item 39 need not be completed.

H. L. Pugh

The above letter will not be printed in the Navy Department Bulletin.

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JOINT LETTER

BUMED CIRCULAR LETTER 51-34 19 February 1951

From: Chief of Naval Personnel
Chief of Bureau of Medicine and Surgery
Commandant of the Marine Corps

To: Commanders, All Naval Training Centers
Commanding Generals, U. S. Marine Corps Recruit Depots, Parris Island, S. C., and San Diego, Calif.

Subj: Standards for discharge of enlisted and inducted male personnel by reason of physical disability

Ref: (a) BuPers-BuMed-MarCorps Joint Letters Pers-66-JMS P19-1, BuMed-33-RAB P3-1/P19-1 C/L 50-41a, MARCORPS DM-1577 ebg dated 21 April 1950
(b) Physical standards and physical profiling for enlistment and induction (A.R. 40-115)

(c) Regulations prescribed by SecNav for the administration of Title IV of the Career Compensation Act of 1949

1. The Secretary of Defense has directed that during the life of the Selective Service Act, no person, whether enlisted or inducted, will be discharged for medical reasons by any military department if his reclassified physical profile serial (see reference (b)) is at the minimum, or higher than the minimum, profile serial acceptable for induction, provided his services can be utilized effectively. (This includes all male enlisted personnel now in service and those enlisted or inducted in any branch of naval service while the Selective Service Act of 1948 is in effect.) It has been further directed that, in general, any man who has been enlisted or inducted shall be discharged from the U. S. Naval Service for disability (medical reasons) only when:

(a) In the judgment and opinion of competent medical personnel he has become functionally incapable of performing useful duty during the remainder of his service with due consideration given to whether his scaled-down physical profile serial is consistent with any assignment wherein he could perform useful work within the military department in which he is serving.

(b) Or he has a medical condition of such nature that, in the opinion of competent medical personnel, to retain him for further active duty would aggravate such condition to the detriment of his future health and well-being.

(c) Or his retention would, in the opinion of competent medical personnel, jeopardize the health and safety of his service associates.

2. In view of the foregoing, enlisted or inducted members shall not be discharged under the authority of reference (a) or recommended for discharge or retirement for physical disability (reference (c)) if their physical profile serial is at the minimum or higher than the minimum profile serial acceptable for induction, unless the members' services cannot be utilized effectively. If however, the members' revised physical profile serial falls below the minimum serial for induction in any column of the Pulhes chart (reference (b)), discharge for physical disability may be effected under the authority of reference (a) or discharge or retirement may be effected in accordance with the provisions of reference (c).

C. B. Cates H. L. Pugh J. W. Roper

The above letter will not be printed in the Navy Department Bulletin.

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JOINT LETTER

BUMED CIRCULAR LETTER 51-35 21 February 1951

From: Chief of Naval Personnel
Chief, Bureau of Medicine and Surgery
Commandant of the Marine Corps
To: All Ships and Stations

Subj: Cancelation of joint BuPers-BuMed-MarCorps letter

1. The following joint BuPers-BuMed-MarCorps letter is considered to have served its purpose and is hereby canceled:

NDB No.	BuMed Cir Ltr No.	Subject
47-927	47-123	Casualty Reporting Procedure and Release of Casualty Information for Publication.

J. W. Roper H. L. Pugh C. B. Cates

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BUMED CIRCULAR LETTER 51-36 21 February 1951

From: Chief, Bureau of Medicine and Surgery
To: Commanding Officers, U. S. Naval Hospitals (Continental)

Subj: Replacement of Red Cross Medical and Psychiatric Social Workers

Ref: (a) BuMed Cir Ltr No. 43-68
(b) BuMed Cir Ltr No. 43-110

1. References (a) and (b) are canceled.

2. The American Red Cross has informed the Armed Services that all Red Cross social workers engaged in social case work, both psychiatric and medical, will be withdrawn from Armed Services hospitals during the current fiscal year. Recreational services in the hospitals will be continued by the Red Cross, and a Field Director and Assistant Field Director, with appropriate clerical staff, will be maintained in each installation where such positions now exist.

3. The social workers lost by this withdrawal of services are to be replaced by Civil Service employees. The Red Cross has requested that this replacement begin as soon as feasible, and be completed by 30 June 1951.

4. The Bureau is developing guide-line job descriptions covering the different types of social worker positions that will be used in Navy hospitals. It is anticipated that they will be established in GS-7 and GS-9 levels. The Bureau will issue instructions at an early date covering the procedure to be followed in classifying these positions.

5. It has been determined that the register established in the central office of the Civil Service Commission for social workers will not be satisfactory for filling these positions. Accordingly, the Bureau, in consultation with other branches of the Armed Services, is developing new basic qualifications for the incumbents of these positions. It is proposed to request the Civil Service Commission to conduct a new examination. Since this will require a considerable period of time for accomplishment, it is further proposed to request the Commission to abolish the present register and grant authority for temporary appointments, using the qualifications requirements recommended by the Armed Services. At such time as the Commission approves these new qualifications requirements, they will be furnished to the addressees together with the guide-line job descriptions mentioned above and more detailed instructions for establishing and filling these positions.

6. The civilian ceiling of the addressed activities will be increased sufficiently to provide for the social workers and supporting clerical help as required. Request for increase in allotment should be submitted, if required, after the positions have been established and filled.

7. Guide-line job descriptions will indicate the administrative and technical supervision to be provided these workers. It is anticipated that these employees will be assigned to the Executive Officer for administrative control and to the local Field Director of the American Red Cross for technical supervision.

H. L. Pugh

The above letter will not be printed in the Navy Department Bulletin.

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BUMED CIRCULAR LETTER 51-37 21 February 1951

From: Chief, Bureau of Medicine and Surgery
To: All Ships and Stations

Subj: Handbook of the Hospital Corps, U. S. Navy

Ref: (a) BuMed Cir Ltr No. 49-70; NDB Jan-Jun 1949, 49-425, p 82
(b) BuMed Cir Ltr No. 49-157; NDB Jul-Dec 1949, 49-855, p 127

1. References (a) and (b) are canceled.

2. All stocks of the 1949 edition of the Handbook of the Hospital Corps are exhausted. A new edition is being prepared.

3. Until the new edition is available, orders for the Handbook will be filled from the limited residual stocks of the 1939 edition. In view of the limited supply, orders shall be kept to an absolute minimum and any overstocking avoided. Hospitals and hospital corps schools shall issue copies on a custody basis only.

4. The 1939 Handbooks are available by requisition from the Bureau of Medicine and Surgery, Department of the Navy, Washington 25, D. C. Ordering activity shall submit justification for quantity ordered.

H. L. Pugh

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BUMED CIRCULAR LETTER 51-38 21 February 1951

From: Chief, Bureau of Medicine and Surgery
To: BUMED Management Control Activities

Subj: Amendment of activity schedules of wages.

Ref: (a) NCPI Cover Sheet No. 255 of 23 January 1951
(b) Art. 10-5(5), Manual of the Medical Department

1. A recent amendment of NCPI 250 (Wage Administration), under cover of reference (a), delegated optional authority to bureaus and offices to amend activity schedules of wages by the addition of ratings which already appear on the Area Schedule applicable to the activity concerned.

2. This amendment is primarily designed to facilitate the operations of those bureaus which exercise management review for all Group II and Group III ratings established at their activities. The Bureau of Medicine and Surgery does not require prior Bureau authorization for Group II and Group III ratings, and it will not exercise the option at this time. Medical Department activities' requests for authorization to use ratings already listed on the Area Schedule of Wages shall continue to be submitted for approval of the cognizant Area Wage and Classification Offices, in accordance with present practice.

3. The foregoing shall not be considered as modifying the Bureau's requirements for prior authorization of non-IVb supervisory ratings, as provided in reference (b).

H. L. Pugh

The above letter will not be printed in the Navy Department Bulletin.

Food Service Course for MSC and HC Officers: The Department of the Army has allocated a quota for a limited number of officers of the Medical Service Corps (Administrative and Supply) and Commissioned Warrant and Warrant Officers of the Hospital Corps, U. S. Navy, to attend the next course of instruction in Food Service to be given at the Army Quartermaster School, Quartermaster Center, Fort Lee, Virginia, from 14 May to 1 September 1951.

Eligible officers desiring to attend the course should submit requests to Chief, Bureau of Medicine and Surgery (Attention: Code 345) prior to 16 April 1951. Requests may be made by dispatch if the time element requires such action. (Professional Div., BuMed)

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NAVY DEPARTMENT
BUREAU OF MEDICINE AND SURGERY
WASHINGTON 25, D. C.

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